Intraoperative localisation of a urachal bladder tumour prior to partial cystectomy

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BACKGROUND

Partial cystectomy is a bladder preserving treatment option for patients with urachal adenocarcinoma of the bladder. The procedure involves the full thickness surgical removal of the tumour, the surrounding bladder wall and the urachal remnant. Oncologically, it is imperative that the excision margins are clear of disease, whereas a functionally adequate residual bladder capacity is valued by the patient. It is not always possible to palpate the extent of the tumour intra-abdominally. We describe a simple technique of using methylene blue to outline the border of the planned excision.

Figure 1 Urachal adenocarcinoma of bladder

TECHNIQUE

Cystoscopy is performed prior to laparotomy and the tumour identified (Fig 1). A 6F ureteral Axxcess™ catheter (Boston Scientific, Hemel Hempstead, UK) and 27G needle (Olympus KeyMed Ltd, Southend-

Figure 2 View of primed needle position within ureteric catheter

Figure 3 Injection of methylene blue into detrusor muscle

Figure 4 Circumferential mark encircling lesion visible at laparotomy

Figure 5 Excised urachal bladder lesion

on-Sea, UK) are introduced intravesically via a catheter deflector until the bevel of the needle is visible (Fig 2). A 10ml syringe containing 1ml of methylene blue (methylthioninium chloride 1% in 10ml, Martindale Pharma, Romford, UK) and 9ml normal saline is connected to the needle. Under direct vision, 1ml of methylene blue solution is injected into the detrusor muscle 2cm from the macroscopic margin of the bladder lesion (Fig 3). This is repeated at intervals circumferentially around the lesion. At laparotomy the methylene blue is visible

on the serosal surface of the bladder (Fig 4) and excision performed around the marked area (Fig 5).

DISCUSSION

Methylene blue marking of bladder lesions is simple, precise and safe. Although the technique is not novel,¹ in our recent experience of three rare cases of urachal adenocarcinoma, it has facilitated ensuring negative margins at partial cystectomy.

Reference

1. Nargund VH, Steward PA. Endoscopic localization prior to partial cystectomy. *Br J Urol* 1994; **73**: 455–456.

A simple aid to insertion of an irrigation catheter for flexor sheath washout

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BACKGROUND

The standard treatment of pyogenic flexor tenosynovitis is immediate drainage and washout of the tendon sheath, for which various techniques have been described.^{1–3} Despite these, it may be difficult to thread a catheter into the flexor sheath and an aid such as a probe or guidewire may be required to assist its passage.^{4,5} We describe a simple aid for irrigation catheter insertion.

TECHNIQUE

The flexor tendon sheath is opened via a standard incision just distal to the A5 pulley and a second incision over the distal palm at the proximal border of the A1 pulley. A fine, flexible catheter (external diameter 0.85mm, internal diameter 0.45mm) is introduced into the flexor sheath with the aid of a unique wishbone introducer from a continuous peripheral nerve block set (Techniplex®; Vygon (UK) Ltd, Swindon, UK) (Fig 1). A 2.5ml syringe is used for sheath washout. The catheter may be removed at the end of the procedure or left in situ for continuous irrigation.

DISCUSSION

The infusion catheter and wishbone introducer described are used primarily for peripheral nerve blocks and similar infusion sets are available in most plastic and hand surgical units, costing about £24 per set. Although a conventional feeding/umbilical catheter costs between £2 and £3, the wishbone introducer allows the easy and atraumatic insertion of a finer yet rigid catheter, offering another option to surgeons, especially in difficult cases.

References

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Figure 1 Irrigation catheter with wishbone introducer aiding flexor tendon sheath washout